



Commonwealth of Massachusetts Group Insurance Commission

*Your
Benefits
Connection*

HMO Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, the Group Insurance Commission will determine student coverage eligibility and effective dates. Once this application has been approved by the GIC, your HMO will contact you every spring and every fall thereafter to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify the Group Insurance Commission when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from the Group Insurance Commission. You may also receive information concerning these options by calling the Group Insurance Commission at (617) 727-2310.

We can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

*For additional information about student coverage, see our website:
www.mass.gov/gic*



HMO STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the GIC. Be sure to refer to important information on page one of this application.

Name of Insured _____ Insured's Social Security # _____

Address _____ Telephone Number (____) _____

Place of Employment _____

Name of Student _____ Student's Social Security # _____

Relationship to Insured _____ Student's Date of Birth ____/____/____

Name of Educational Institution Student is Attending _____

Address of School _____

City, State, Zip _____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes____ No____

I understand that I must notify the GIC when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured _____ Date _____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted: _____ Expected date of graduation: Month _____ Year _____

a. Full-time _____ If full-time has he/she been considered full-time since admission? ____ yes ____ no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time _____ c. Minimum full-time credit hours _____

d. Is the student on a medical leave of absence? Yes _____ No _____ If yes, leave approved From _____ To _____

Name of Educational Institution

Name of Registrar

PLEASE AFFIX SCHOOL SEAL

Date

Signature of Registrar or Designee

Return application to:
Group Insurance Commission, PO Box 8747, Boston, MA 02114-8747

III. FOR GIC USE ONLY

Insured Parent's Coverage _____ Effective Date ____/____/____ Agency/Division ____/____/____

Status

Approved _____ Effective Date ____/____/____ Expiration Date ____/____/____

Denied _____ Reason _____

Reviewed by _____ Date ____/____/____